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ABSTRACT

The incorporation of published outcome data into clinical practice plays a significant role in determining appropriate treatment interventions and the efficacy of various modalities. If practitioners are willing to conduct their own outcome research, the results will enhance the quality of care for clients and improve the quality of information provided to funding sources. When simple measures of effectiveness are implemented, the demonstrated outcomes from such research can be a very effective tool for providing evidence of treatment success. To begin outcome research, counselors must have an understanding of efficacy studies and effectiveness studies. Counselors can use published efficacy studies to make initial choices about treatment interventions, and then conduct effectiveness studies on their own practice to measure the success of their treatment. The results of effectiveness studies can be useful in helping with allocation of resources and in marketing programs to community and health care organizations. (Contains 28 references.) (JDM)

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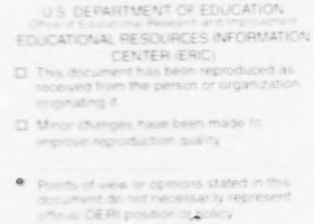
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Chapter Fourteen

Counseling Outcome Research: Making Practical Choices for Real-World Applications

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Abstract

Mental health practitioners are increasingly being called upon to demonstrate the effectiveness of their clinical interventions. Effectiveness studies are a type of outcome research that can provide useful information to clinicians and to managed care organizations.

In an age of managed care, counselors are increasingly being called upon to demonstrate the effectiveness of their clinical interventions (Granello, Granello, & Lee, 1999). The ability to demonstrate treatment success is rapidly becoming the standard by which reimbursement is judged (Sexton, 1996). In spite of these pressures, many counselors have been left unprepared to meet this new standard. Historically, mental health practitioners used professional judgment and theoretical beliefs to determine treatment interventions. Fee-for-service policies and insurance reimbursement were assumed, and insurance companies rarely questioned treatment decisions (Plante, Couchman, & Diaz, 1995). In the current practice environment, however, counselors who cannot demonstrate their successes may find themselves unable to survive professionally (Burlingame, Lambert, & Reisinger, 1995).

Although the demonstration of treatment effectiveness is increasing in importance, many mental health professionals and agencies have resisted participation in outcome measures, and there is widespread resistance among mental health professionals to beginning their own assessment programs (Plante, et al. 1995). Studies have revealed that the vast majority of mental health practitioners report that they do not read research or engage in research and believe that

research has little or no impact on their counseling practices (Cohen, Sargent, & Sechrest, 1986; Falvey, 1989). In 1983, Norcross and Prochaska found that when presented with 14 reasons to select a particular approach or orientation with a client, the psychologists in their study rated outcome research 10th, just above "family experiences" and "own therapist's orientation." More recently, Norcross (2000) noted there was little evidence that this ranking had improved significantly during the past 17 years, although he predicted that the recent emphasis on the importance of outcome research should result in increased reliance on such research in the future. A recent survey found that although the majority of the clinical diplomates of the American Board of Professional Psychology (65%) supported the development of empirically supported treatments, the majority of respondents (54%) did not routinely use them in their practices (Plante, Anderson, & Boccaccini, 1999).

Both philosophical and practical concerns have been identified at the root of the resistance to engaging in outcome research and incorporating research results into practice. Philosophically, some providers have argued that the invasion of accountability into mental health care has negatively affected therapeutic decision making (Sherman, 1992). Some argue that the therapeutic process itself is not quantifiable (Mirin & Namerow, 1991) or that clinical flexibility, clinical judgment, and creative expression of theory should be valued more than scientific method and statistical analysis (Havens, 1994). Still others argue that time spent in evaluation could be better used in treatment (Plante, et al. 1995). Even among clinicians who are willing to conduct outcome research, practical concerns often stand in the way. Practitioners may erroneously believe that the task will be overwhelming or that a program of research will necessarily be costly, complex, and time-consuming (Granello et al., 1999). What has become apparent is that few mental health practitioners have received the training they need to conduct such research. Research methods courses in university programs often focus on understanding laboratory research with true experimental designs that are often impossible to implement in real-world assessment (Sandell, Blomberg, & Lazar, 1997). Thus, practitioners may be ill prepared to conduct their own outcome research, regardless of their willingness to do so.

The incorporation of already published outcome data into clinical practice plays a significant role in determining appropriate treatment interventions and the efficacy of various modalities (Sexton, 2000). Bridging the gap between research and practice is essential (Whiston & Coker, 2000). However, if a practitioner is willing to conduct his or her own outcome research, in conjunction with already published research to support general clinical interventions, the result will be

enhanced quality of care for clients and improved quality of information provided to funding sources (Granello, Granello, & Lee, in press). Measuring treatment effectiveness need not be a difficult or cumbersome task. Simple measures of effectiveness can be implemented quite easily, and the demonstrated outcomes from such research can be a very effective tool for providing evidence of treatment success.

Methodological Considerations

To engage in outcome research, counselors must first have an understanding of the two main types of research that are used to demonstrate clinical success: efficacy studies and effectiveness studies. *Efficacy studies* use random assignment to treatment and control group, manualize treatment, and use participants who meet criteria for a single diagnosed disorder (Seligman,

1995; Wampold, 1997). Additionally, there are clearly defined inclusion and exclusion criteria for clients and an adequate sample size to obtain the necessary statistical power (Fishman, 2000). Efficacy studies provide useful information and are appropriate designs for laboratory studies or settings in which highly controlled manipulation of variables is possible (Sandell et al., 1997). However, these studies are very expensive and time-consuming and often are funded through a university or through a grant offered by a foundation or a pharmaceutical company.

Effectiveness studies, on the other hand, attempt to answer how well clients fare under treatment as it is actually practiced in the field. Such studies yield useful and credible information that can empirically validate psychotherapy (Lambert, Huefner, & Nace, 1997). Effectiveness studies recognize that less-than-methodologically-ideal situations exist in the field. Among these situations are that (a) therapy is not always of fixed duration, and typically continues until the client improves or quits or until insurance coverage runs out; (b) psychotherapy often is eclectic rather than manualized and typically is self-correcting (e.g., if one technique is not working, then another usually is tried); (c) clients typically present with multiple problems, some subclinical and some diagnosable, rather than the pure diagnoses represented in efficacy studies; and (d) psychotherapy in the field typically is concerned with improvements in general functioning rather than in specific symptom relief, which is the typical measure in efficacy studies (Seligman, 1995).

Efficacy and effectiveness studies have different strengths and limitations. Efficacy research typically has high internal validity but low external validity. The conditions under which efficacy research is

conducted are so structured that there is a high degree of confidence that changes that occur are due to the treatment, not to confounding variables. However, the conditions under which efficacy research is conducted are often so dissimilar to what happens in the field that there is a low degree of confidence in generalizing the results of a particular study to field conditions. Conversely, effectiveness studies have high external validity but low internal validity. Because they sample a population directly from the field, there is a high level of confidence that results can be generalized to other members of the population (Fishman, 2000). The lack of a control group and of therapist adherence to specific treatment interventions are noteworthy, however, and lead to concerns about confounding variables (e.g., the passage of time) that might affect treatment results (Granello et al., 1999). Overall, efficacy and effectiveness studies provide complementary research designs. Counselors can use published efficacy studies to make initial choices about treatment interventions, then conduct effectiveness studies on their own practice to measure the success of their treatment (Granello & Hill, 2000).

Research Design

Research design is guided by the research questions under investigation (Granello & Hill, 2000). What specific information does the counselor wish to have about his or her practice or clients? Clinicians wishing to engage in tracking the success of a single client for reimbursement purposes would ask different research questions than would those wishing to investigate their treatment success with their overall client load or with clients having particular disorders (e.g., anxiety disorders).

Many effectiveness studies follow a pre-post or pre–post–follow-up design. That is, clients are given an instrument or series of instruments upon entering treatment, and the same instrument or instrument battery is given at discharge, and if desired, at pre-designated follow-up periods (typically 3, 6, or 12 months, or all three). Other types of effectiveness studies track the progress of a single client at various points in treatment (e.g., every week, every month), on a specific rating scale, with results that can be represented graphically to demonstrate progress. Still other studies use existing data from client records (e.g., Global Assessment of Functioning scores) to make comparisons over time or across client groups. Thus, for a single client, the counselor may choose to measure the reduction of a very specific symptom and engage in a single-case pre-post design, using a repeated measures *t*-test, or may choose to forego statistical analysis in favor of a graphic representation of multiple data points. To measure symptom

reduction in multiple clients, the clinician may wish to collect demographic data and make comparisons (via repeated measures MANOVA) of reduction of various types of symptoms depending on demographic data (e.g., age, gender) or Axis I diagnosis. From this information, for example, a clinician could learn that he or she is very effective at helping clients with clinical depression to reduce their cognitive symptoms of depression but not as effective at helping to reduce the behavioral components. Likewise, she or he could discover that the treatments implemented seem to work well for female clients but are less successful with male clients. Clearly, all of this information can yield valuable data for improving clinical effectiveness.

Selecting Instruments

Instrumentation determines the type of data that can be obtained, and thus the choices regarding instrumentation must be made with care. The basic research questions that are being investigated should guide the instrument selection. Clinicians are strongly encouraged to use existing instruments with established validity and reliability whenever possible, rather than attempting to develop their own. Independently developed instruments require large commitments of time and resources to ensure reliability and validity, and once data is collected, no comparisons can be made with norming groups from existing research (Hansen, 1999). The test manual for a published instrument should provide norming samples that can help determine whether the person or sample being tested should be compared with the test norms. When selecting from existing instruments, practitioners should consider the cost of the instruments, including time required to administer, score, and analyze the results. Further, it is important to consider a measure that is sensitive to changes in symptomatology (Burlingame et al., 1995; Waxman, 1994; see Lambert, Ogles, & Masters, 1992 for methods to select and analyze the appropriateness of outcome instruments).

Using a small battery of instruments, rather than just one, may provide the best information. It may be useful to collect data from several different sources (e.g., client report, clinician rating, family/teacher rating) to gain a clearer picture of the client's functioning (Sexton, Whiston, Bleuer, & Walz, 1997). Counselors should take care not to overburden their clients or to administer so many instruments that they are overwhelmed with data, however. Two or three short instruments, plus a demographics questionnaire, may be sufficient (Granello et al., 1999). Clinician ratings (e.g., a Global Assessment of Functioning score) can be an important component of treatment evaluation, as clinicians may be in a unique position to provide insight

into patient progress. Using clinician ratings as a stand-alone measure of progress is unwise, however, as they have been criticized for their subjectivity (McLeod, 1994).

Using the Results

The results of effectiveness studies can be useful in a variety of ways. In several large-scale outcome studies conducted by the authors, data on program effectiveness were useful in marketing both adult and child partial hospitalization programs to the community, to insurance companies, and to managed care panels (Granello et al., 1999; Granello et al., in press). Importantly, a measure of client satisfaction was an essential part of this research and was highlighted in marketing materials. In a study of an eating disorder unit, results of the effectiveness research were used to increase hospital resources allocated to that unit (Granello & Hill, 2000).

Conducting such research has other, less tangible results. Clinicians with access to data can use those data to improve their treatment interventions, and research has found that practitioners' efficacy improves when they are involved in research (Hauri, Sanborn, Corson, & Violette, 1988). Reports from agencies that make systematic attempts to investigate their outcomes indicate that once clinicians become aware of variations in client outcomes, they are in a better position to generate ideas for improvement and hypotheses for further testing ("Authors pose," 1997). Thus, data collection and analysis may have great clinical importance.

Tips for Implementation

Although effectiveness studies clearly have limitations, we agree with Seligman's (1995) assertion that they are a complementary research method to efficacy studies. They provide practitioners with research that is clinically useful and important for negotiating managed care contracts, while allowing meaningful research to be conducted with minimal disruption to their work with clients.

Practitioners wishing to conduct outcome research in their own practice are encouraged to keep a few important suggestions in mind (see Granello et al., 1999 for a more complete discussion on implementation of effectiveness studies).

1. Effectiveness studies cannot be all things to all people. Complex designs with multiple administrations and a large number of instruments may so overwhelm the clinician that they are never completed or, once completed, are never statistically analyzed in a meaningful way. For practitioners just beginning to collect

data, our recommendation is to keep the data collection and analysis manageable.

2. Although outcome research need not be cost prohibitive, some foresight will be necessary to set aside sufficient funds for instruments and, if necessary, data analysis. We have found that university-agency collaboration, although not necessary, can provide a symbiotic relationship (data for the university, data analysis for the agency).
3. As much as possible, the collection of data should be integrated into clinical practice (e.g., put pretests in admissions packets so they are not forgotten).
4. For clinicians not currently collecting data, any step, however small, is a step in the right direction. Collecting data on treatment effectiveness can provide both an external benefit in terms of marketing and an internal benefit in validating and improving clinical success.

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